Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
EDWIN J TAEGEL MD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-13-2454-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 28, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At your request, a Post Designated Doctor Required Medical Examination was carried out on the above claimant in 11/26/12. All submitted records were reviews.

The purpose of the examination was to determine maximum medical improvement, impairment rating, extent of injury, and return to work."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… The following is the carrier's statement with respect to this dispute of 11/26/12. The requestor performed a required medical exam on the date above then billed Texas Mutual codes 99456-RE at $350.00, 99456-RE at $150.00, 99456-RE at $500.00, and 99456-RE at $250.00 (Attachment 1) Texas Mutual reviewed the billing and attached documentation, and then issued payment of $500.00 for the Return to Work exam, coded 99456-RE. The remaining codes were denied. Section (j)(4)((C)(iii) of Rule 134.204 indicates when the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the doctor should bill the appropriate CPT Code with modifier "WP". The RE modifier applies to return to work evaluation of medical care exams only. Further, the Commissioner Order lists the following exams to be done- MMI,IR and RTW. (Attachment 2)

The requestor submitted a request for reconsideration (RFR) that Texas Mutual received 3/27/13. (Attachment 3) Rule 133.250 (d)(1) requires the same billing codes and dollar amounts as the original bill. The RFR bill had a different dollar amount and the same CPT codes (including the incorrect modifier) but with the addition of a new modifier "WP." This RFR bill actually constitutes a new bill, which is untimely."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 26, 2012	CPT Code 99456-RE-WP	$500.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedure for medical bill submission by health care provider.
3. 28 Texas Administrative Code §133.250 sets out the procedure for reconsideration for payment of medical bills.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
   - 732 – Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed.
   - CAC-29 – The time limit for filing has expired
   - 731 – Per 133.20 Provider shall not submit a medical bill later than the 95th day after the date of service, for services on or after 9/1/05

Issues

1. Did the requestor bill the respondent in accordance with 28 Texas Administrative Code §133.20 and 133.250?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided."

   28 Texas Labor Code §133.250 states: "(d) A written request for reconsideration shall: (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill; (2) include a copy of the original explanation of benefits, if received, or documentation that a request for an explanation of benefits was submitted to the insurance carrier; (3) include any necessary and related documentation not submitted with the original medical bill to support the health care provider's position; and (4) include a bill-specific, substantive explanation in accordance with §133.3 of this title (relating to Communication Between Health Care Providers and Insurance Carriers) that provides a rational basis to modify the previous denial or payment."

   Review of submitted bills to the insurance carrier finds the original bill and the request for reconsideration differ from one another. Original bill is documented as followed with CPT Code 99456-RE with one modifier for the amount of $350.00, 99456-RE with one modifier for $150.00 and 99456-RE with one modifier for $500.00. The request for reconsideration bill documents CPT 99456-RE-WP with one modifier in the amount of $350.00, 99456-RE-WP with one modifier in the amount of $150.00 and 99456-Re with one modifier in the amount of $500.00. The request for reconsideration was not billed in accordance with 28 Texas Labor Code §133.250 (d)(1).
2. The respondent issued payment in the amount of $500.00. Based upon the documentation submitted, no additional reimbursement is recommended

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	05/30/14 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.